EDS Document Management Unit

INDIANA HEALTH COVERAGE PROGRAMS

Eligibility Operating Procedures Manual

LIBRARY REFERENCE NUMBER: CLEG10001
REVISION DATE: JULY 2005
VERSION 2.0

Library Reference Number: CLEG10001

Document Management System Reference: Eligibility Operating Procedures Manual

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Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	October 2000	Multiple	2000 updates	Kari Clendenen
Version 2.0	October 2005	Multiple	2005 2nd quarter updates plus full re-edit and reformatting	Tim Troxell

Table of Contents

Section 1: Introduction

Overview

In Indiana, the eligibility process begins with the caseworker at the county level. Using the Indiana Client Eligibility System (ICES), the caseworker enters the data necessary to enroll a prospective member in the Indiana Health Coverage Program (IHCP).

Indiana*AIM* maintains a daily interface with ICES to add or update member data on the system. Accurate and up-to-date information is necessary to allow the accurate processing of claims for eligible IHCP members. The majority of the member data is obtained through this automated function and is transparent to the user. Member data includes:

- Member eligibility information including program and aid category information
- Spend-down
- Specific program eligibility
- Identification card information
- Level of care (see the *IOC/LOC/PASSARR Operating Procedures Manual* for more information)
- Managed Care lock-in (see the *Managed Care Operating Procedures Manual* for more information)
- Utilization restrictions (see the *Surveillance and Utilization Operating Procedures Manual* for more information)
- Medicare Coverage (see the *Third Party Liability Operating Procedures Manual* for more information)
- Medicare Buy-in (see the *Medicare Buy-In Operating Procedures Manual* for more information)

Various eligibility reports are produced for ongoing monitoring of member eligibility and problem identification and resolution by EDS, Indiana Family Social Services Administration (FSSA), and County Divisions of Family Resources.

Indiana*AIM* also produces IHCP member identification cards. These are permanent, plastic cards that include a magnetic strip allowing providers access to the most current system information about a specific member at the time services are rendered.

Goals and Objectives

The primary objective of the Eligibility team is to maintain member-eligibility data transmitted from ICES and issue identification cards accordingly. To meet this objective, the Eligibility team set the following goals:

- Ensure compliance with all federal regulations and state statutes that relate to member data maintenance
- Maintain a qualified and highly trained staff to carry out the responsibilities and tasks detailed in this manual

Section 2: Organization and Staffing

The TPL supervisor oversees the operation and management of the Eligibility team. The TPL supervisor hires, trains, and monitors unit staff. The Eligibility team lead helps to coordinate work flows and projects. The Eligibility team responds to eligibility requests made by the Office of Medicaid Policy and Planning (OMPP) and other EDS staff. The eligibility analyst processes 590 enrollment. This process is addressed in the *590 Eligibility Enrollment Operating Procedures Manual*.

TPL Supervisor

The role of the TPL supervisor is to:

- Direct the Eligibility team in ensuring that eligibility responsibilities are carried out timely and accurately
- Review and make recommendations on changes or enhancements to eligibility policy, procedures, edits, and reporting
- Oversee and approve or disapprove all staffing changes

Eligibility Team Lead

The role of the Eligibility team lead is to:

- Serve as lead for all Eligibility team functions
- Serve as the eligibility liaison with FSSA and the Indiana Client Eligibility System (ICES) staff
- Oversee and coordinate IHCP identification card production and distribution
- Train new and existing staff about procedures and procedural changes
- Perform ongoing reviews of eligibility policies, procedures, and reporting and make recommendations to the TPL supervisor as appropriate
- Interact with state, county, and other government agencies as related to eligibility
- Initiate Change Orders (COs) including writing, testing, and follow-through

Eligibility Team Member

The role of the eligibility team member is to:

- Research, monitor, and reply to related inquiries from the OMPP and state and county offices

Eligibility Team Organization

The Eligibility team is organized as illustrated in Figure 2.1.

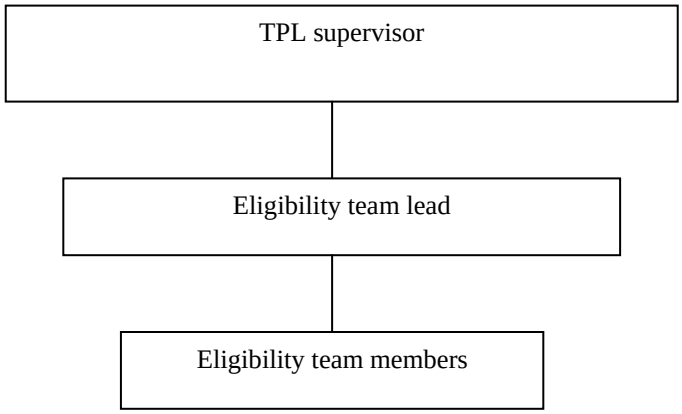

Figure 2.1 – Eligibility Team Organization

Section 3: Work Flow Procedures

Overview

The Eligibility team primarily oversees the automated process of member data maintenance, which itself accepts and maintains an accurate, current, and historical source of eligibility and demographic information on individuals eligible for IHCP. Maintaining member data is required to support the claims processing and reporting functions and to support the state of Indiana eligibility verification system. The Eligibility team's main responsibilities include oversight of identification card production, referral of member inquiries as appropriate, and work COs.

ICES

As of January 1, 1994, all County Offices of the Division of Family Resources implemented ICES. ICES allows the caseworker to input all required eligibility data in order to systematically determine IHCP eligibility. After a member is determined to be eligible under a system-specified aid category, a member identification number (RID number) is systematically assigned to the member. The member is also assigned a case number. The case number applies to the entire household of the eligible member, whereas the RID number applies to the member within the case. The RID number is a unique number that is assigned once per lifetime. Under no circumstances will a RID number be assigned by Indiana*AIM*.

Member Eligibility Data

Recipient windows provide member information necessary for the accurate processing of claims. As claims are adjudicated, the system first searches the member tables for data including the following:

- Billed dates of service in relation to dates of IHCP eligibility
- Coverage under a specific program
- If spend-down is applicable
- If the member has certain service restrictions
- Where the member has approval for the level of long-term care being billed

Many other windows, such as Provider and Third Party Liability, contain protected fields that are loaded from the member tables. Refer to the *Teleprocessing Users Guide – Eligibility* for information on all Eligibility windows.

Indiana Health Coverage Programs Identification Cards

The member IHCP identification card is a plastic card with a magnetic strip that allows the provider access to the member's current eligibility including the following:

- Provider number
- RID number
- Social Security Number (SSN)

- Name
- Date of birth
- IHCP – Y or N
- From and To dates of service
- Program eligibility
- Inquiry verification number
- Managed care – PMP
- Lock-In – Provider
- Spend-down – Y or N
- Spend-down met date
- Medicare Coverage – Y or N
- Qualified Medicare Beneficiary (QMB) – Y, N, or A (Also)
- TPL – Y or N (If yes, policy data available up to seven policies)
- Nursing home – Y or N
- Patient liability
- Several audit limitations directed by the provider type and specialty

The face of the card shows the member's RID number, full name, sex, and date of birth. The card must be presented to the provider each time the member requests services.

The process of producing member IHCP identification cards is automated. The following is the process for card production and distribution.

1. The caseworker enters eligibility data or a reissue card request into the ICES system.
2. This data is transmitted daily to Indiana*AIM*.
3. Indiana*AIM* produces the cards and mails them to the member's home address within three days.
4. If the card is undeliverable, it is returned by the Post Office to the County Office of the Division of Family Resources.

The process of monitoring and reordering stock is maintained by computer operations. (Access is granted for systems and operations staff only.)

Section 4: Windows

Refer to the appropriate Teleprocessing User's Guide or Systems Documentation manual for additional information on screen access, edits, and functionality.

Section 5: Reports

Total ID Card Counts by County (ELIG-0001-D)

This report lists each of the 92 counties alphabetically with the total number of ID cards that were issued for the week. This number includes all replacement cards as well as new cards. The purpose of the report is to allow EDS and Family and Social Services Administration (FSSA) to view the weekly counts for the ID card generation.

ID Card Summary (ELG-0002-D)

This report lists the total ID cards being generated according to the reason codes from the ID Card window. The purpose of the ID Summary Report is to allow EDS and FSSA the ability to monitor card production.

ICES Eligibility Update Error Report (ELG-0003-D)

This report lists the attempted update ICES has transmitted to EDS that has not been accepted in the Indiana*AIM* database. The appropriate action must be taken by ICES staff to correct these transactions.

Aid Categories With Age Limits Report (ELG-0410-M)

This report lists all of the members whose open eligibility segments fall beyond the boundaries of the age or time limitations defined by the applicable aid category. For example, if a member has an open eligibility segment of MA 2 (Medicaid for children between 6 – 19), the member should not be five years of age or younger or 20 years of age or older. If members are younger than or equal to five years of age or older than or equal to 20 years of age, they will appear on this report.

Explanation of Medicaid Benefits Report (ELG-9001-M)

The Explanation of Medicaid Benefits (EOMB) is a system-generated letter sent to a randomly selected one percent of the IHCP member population. This letter assists in the identification of potential program fraud and helps conserve funds provided for the IHCP members.

Summary of Recipient EOMBs (ELG-9002-M)

This report lists the total number of EOMBs produced, the date they were produced, the RID Number that had an EOMB produced, the number of claims reported for each member, and the total dollar amount that was reported on the EOMB for each member. This report allows EDS and FSSA to identify the number of EOMBs produced.

Section 6: Forms and Letters

Form and letter templates are stored on *L:\Package Three\Eligibility*. There are no forms or other letters necessary as the transmission of eligibility data is fully automated.

*Section 7: Indiana*AIM *Performance Standards*

Eligibility

Performance Standard

Resolve eligibility transactions that fail one or more edits within three business days of error.

RFP Requirement No.

2.5.1.1.3.a

Quality Process

Frequency: Daily

Personnel: N/A

Procedure

Any eligibility transaction errors resulting from the ICES interface process with Indiana*AIM* will appear on the ICES Eligibility Update Error Report (ELG-0003-D) on a daily basis. This report is distributed to FSSA to forward to ICES for resolution. Level of Care, Managed Care, Restricted Card, and Medicare Buy-In transactions are covered in their respective manuals.

Monitoring

Since the criterion to meet this requirement is automated in Indiana*AIM*, no routine monitoring is performed.

Eligibility

Performance Standard

Produce and submit to the State balancing and maintenance reports from the daily update process by noon on the business day following the update.

RFP Requirement No.

2.5.1.1.3.b

Quality Process

Frequency: Daily

Personnel: N/A

Procedure

These reports include four e-mails and the ICES Eligibility Update Error Report (ELG-0003-D) sent to FSSA and EDS staff for review. The e-mails are as follows:

- ICES Conversion Statistics for a specific date
- List of five RIDS with ID Cards generated on a specific date
- ICES TXNS for Package C Recipients on a specific date
- ICES Un-Link and Link Txns from a specific date

Monitoring

Monitoring is done by the Eligibility Team and FSSA staff on a daily basis.

Eligibility

Performance Standard

Produce and submit to the State balancing and maintenance reports from the monthly reconciliation process by 9 a.m. on the third business day following the run.

RFP Requirement No.

2.5.1.1.3.c

Quality Process

Frequency: Daily

Personnel: N/A

Procedure

There are several reconciliation reports that are available on CO-MAND. Plus there are four reports that are sent to FSSA via email and internal mail. A CSR has been created to automate these reports so that they will be available on CO-MAND as well.

Monitoring

These reports are reviewed each month by both Eligibility Team and FSSA staff.

Eligibility

Performance Standard

Produce and distribute member identification cards to the mailing address contained in the Recipient Master File within three business days of adding new members or receiving a request for a reissued card.

RFP Requirement No.

2.5.1.1.3.d

Quality Process

Frequency: Daily

Personnel: N/A

Procedure

ICES will transmit eligibility data for identification card generation to Indiana*AIM*, which will then produce the card within three business days of the ICES transmission.

Monitoring

Because this process has been moved in-house, daily monitoring occurs through e-mails and documentation located in Operations.

Section 8: Special Information

Table 8.1 – Aid Categories

Public Health Program	Aid Category	Description	AVR Program/Benefit Package
MA	1	Children younger than 19 years old who meet TANF income standards	HH – Package A – Standard Plan Discontinued in 1992
MA	2	Children ages 6-9 under 100 percent FPL	HH – Package A – Standard Plan
MA	3	Wards not IVE eligible under 18	HH – Package A – Standard Plan
MA	4	Title IVE foster children under 18	HH – Package A – Standard Plan
AR	5	ARCH for aged	Traditional Medicaid
AR	6	ARCH for blind	Traditional Medicaid
AR	7	ARCH for disabled	Traditional Medicaid
MA	8	Children Receiving Adoption Assistance (under 19)	HH – Package A – Standard Plan
MA	9	Children ages 1-19, up to 150 percent poverty	HH – Package A – Standard Plan
MA 10 (K2)	10	Hoosier Healthwise – Package C – Children's Plan	HH – Package C – Children's Health Insurance Plan
MA	12	Breast and Cervical Cancer Treatment	HH – Package A – Standard Plan
MA	A	Aged	Traditional Medicaid
MA	B	Blind	Traditional Medicaid
MA	C	Low income families	HH – Package A – Standard Plan
MA	D	Disabled	Traditional Medicaid
MA	DI	Working Disabled MEDWORKS Improved	Traditional Medicaid
MA	DW	Working Disabled MEDWORKS	Traditional Medicaid
MA	E	Extended eligibility for pregnant women	HH – Package B – Pregnant Women
MA	F	Transitional medical assistance	HH – Package A – Standard Plan
MA	G	Qualified Disabled Working Individual (QDWI)	Not eligible
MA	H	Ineligible for AFDC due to deemed income	HH – Package A – Standard Plan Discontinued 1998
MA	I	Qualified Individual – 1	Not eligible
MA	J	Specified Low Income Medicare Beneficiary (SLMB)	Not eligible
MA	K	Qualified Individual – 2	Not eligible
MA	L	Qualified Medicare Beneficiary (QMB)	Traditional Medicaid
MA	M	Pregnancy – Full coverage	HH – Package A – Standard Plan

Table 8.1 – Aid Categories

Public Health Program	Aid Category	Description	AVR Program/Benefit Package
MA	N	Pregnancy – Related coverage	HH – Package B – Pregnant Women
MA	O	Children younger than 21 years old in inpatient psych facility	HH – Package A – Standard Plan
MA	P	No longer used	N/A
MA	Q	Refugee Medical Assistance (RMA)	Traditional Medicaid
MA	R	Room and Board Assistance (RBA)	Traditional Medicaid
MA	S	Ineligible for AFDC due to sibling income	HH – Package A – Standard Plan Discontinued 1998
MA	T	Children ages 18, 19, 20 living with a specified relative	HH – Package A – Standard Plan
MA	U	Ineligible for TANF due to SSI payments	HH – Package A – Standard Plan
MA	X	Newborn – infants born to IHCP members	HH – Package A – Standard Plan
MA	Y	Children younger than one year old under 150 percent FPL	HH – Package A – Standard Plan
MA	Z	Children ages 1-5 under 133 percent FPL	HH – Package A – Standard Plan
MA	1P	Refugee children younger than 19 years old who meet AFDC income standards	HH – Package A – Standard Plan Discontinued
MA	2P	Refugee children ages 6-19 under 100 percent FPL	HH – Package A – Standard Plan Discontinued
MA	3P	Refugee wards not IV E eligible younger than 18 years old	HH – Package A – Standard Plan Discontinued
MA	4P	Refugee Title IV E foster children younger than 18 years old	HH – Package A – Standard Plan Discontinued
MA	5P	ARCH for aged, refugee	Traditional Medicaid Discontinued
MA	6P	ARCH for blind, refugee	Traditional Medicaid Discontinued
MA	7P	ARCH for disabled, refugee	Traditional Medicaid Discontinued
MA	8P	Refugee children receiving adoption assistance	HH – Package A – Standard Plan Discontinued
MA	AP	Aged, refugee	Traditional Medicaid Discontinued
MA	BP	Blind, refugee	Traditional Medicaid Discontinued
MA	CP	Refugee – Low income families	HH – Package A – Standard Plan

Table 8.1 – Aid Categories

Public Health Program	Aid Category	Description	AVR Program/Benefit Package
			Discontinued
MA	DP	Disabled, refugee	Traditional Medicaid Discontinued
MA	FP	Refugee – Transitional medical assistance	HH – Package A – Standard Plan Discontinued
MA	GP	Refugee – Qualified Disabled Working Individual (QDWI)	HH – Package A – Standard Plan Discontinued
MA	HP	Refugee ineligible for AFDC due to deemed income	HH – Package A – Standard Plan Discontinued
MA	LP	Refugee – Qualified Medicare Beneficiary (QMB)	Traditional Medicaid Discontinued
MA	MP	Refugee pregnancy – Full coverage	HH – Package A – Standard Plan Discontinued
MA	NP	Refugee pregnancy – Related coverage	HH – Package A – Standard Plan Discontinued
MA	OP	Refugee children younger than 21 years old in inpatient psych facility	Traditional Medicaid Discontinued
MA	PP	No longer used	N/A
MA	RP	Refugee Room and Board (RBA)	Traditional Medicaid Discontinued
MA	SP	Refugee ineligible for AFDC due to sibling income	HH – Package A – Standard Plan Discontinued
MA	TP	Refugee children ages 18, 19, 20 living with a specified relative	HH – Package A – Standard Plan Discontinued
MA	UP	Refugee ineligible for TANF due to SSI payments	HH – Package A – Standard Plan Discontinued
MA	XP	Newborn – infants born to refugee recipients	HH – Package A – Standard Plan Discontinued
MA	YP	Refugee children younger than one year old under 150 percent FPL	HH – Package A – Standard Plan Discontinued
MA	ZP	Refugee children ages 1-5 under 133 percent FPL	HH – Package A – Standard Plan Discontinued

Section 9: County Offices of the Division of Family Resources County Directory

Refer to the following Web site for County Office information:
http://www.state.in.us/fssa/HTML/DIRECTORY/dfc.html or review the counties listed in Indiana*AIM*.

Glossary

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who will obtain confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

590 Program	A State health coverage program for institutionalized persons under the jurisdiction of the Division of Mental Health and Department of Health.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
AWP	Average wholesale price used for drug pricing.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS about persons receiving Medicaid benefits from the Social Security Administration.
bill	A statement of charges for medical services, the submitted claim document, or electronic record, which may contain one or more services performed.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider that submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.

contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor	Entity with whom the State successfully negotiated a contract pursuant to *IC 12-1-7-17*. **Auditing Contractor** – The entity under contract with the OMPP to conduct audits of long-term-care facilities or other functions and activities as designated by the OMPP. **Fiscal Agent Contractor** – The entity with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities. **Rate-Setting Contractor** – Entities under contract with the OMPP to perform rate-setting activities for hospitals and long-term-care facilities.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
county office	County offices of the Division of Family Resources. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members subject to the limitations of the *Indiana Administrative Code* (IAC).
CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for the IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP program, including State staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
designee	A duly authorized representative of a person holding a superior position.
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through CMS.

DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSS	Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phone lines to Indiana*AIM*. ECC uses point-of-sale devices and personal computers for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECS	Electronic claims submission. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members. See also *MRN*.
EOP	Explanation of payment; term previously used by the IHCP for the claim summary statement – currently known as a remittance advice (RA). Other insurers continue to use the term for claim statements to providers.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for IHCP-eligible members younger than 21 years old offering free preventive health care services, such as screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.

EVS	Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice-response system.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FIPS	Federal information processing standards.
fiscal year	The designated annual reporting period for an entity: State of Indiana – July 1 through June 30 Federal – October 1 through September 30
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCFA	Health Care Financing Administration. Previous name of the Centers for Medicare and Medicaid Services (CMS). See also Centers for Medicare and Medicaid Services, CMS.
HCFA-1500	CMS-approved standardized claim form used to bill professional services. Now referred to as CMS-1500.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	Healthcare Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
HealthWatch	Indiana's preventive care program for Medicaid recipients under 21 years of age. Also known as EPSDT.
HIC	Health insurance carrier number.
HIO	Health insuring organization.

HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management*.
Hoosier Healthwise	Hoosier Healthwise is an IHCP-managed care program that consists of two components, including Primary Care Case Management (PCCM) and risk-based managed care (RBMC).
HRI	Health-related items.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county Division of Family Resources use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IMD	Institutions for mental disease.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
ISMA	Indiana State Medical Association.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
LAN	Local area network.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.

lock-in	Restriction of a recipient to particular providers as determined necessary by the State.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to members.
MAC	Maximum allowable charge for drugs as specified by the federal government.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	A pilot program that was available in Marion county from January 1997 through December 1999. It was a voluntary risk-based managed care program for IHCP enrollees that were considered disabled or chronically ill according to the State's established criteria.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
MEQC	Medicaid eligibility quality control.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NPIN	National provider identification number.
OMNI	A point-of-sale device used by providers to scan recipient ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.

PA	Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
PCCM	Members in the Primary Care Case Management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to IHCP members assigned to the PMP's care.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO)*.
PRO	Peer review organization.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists, and other providers of care, who contract directly with the MCO.

RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
RFI	Request for Information.
RFP	Request for Proposals.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
State	Spelled and capitalized as shown, State refers to the State of Indiana and any of its departments or agencies.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.

SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the Centers for Medicare and Medicaid Services (CMS) that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR, including the following SPR requirements: • Statistical analysis • Exception processing • Provider and member profiles • Retrospective detection of claims processing edit, audit failures, and errors • Retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards • Retrospective detection of fraud and abuse by providers or members • Sophisticated data and claim analysis including sampling and reporting • General access and processing features • General reports and output
systems analyst or engineer	Responsible for performing the following activities: • Detailed system and program design • System and program development • Maintenance and modification analysis and resolution • User needs analysis • User training support • Development of personal IHCP knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TPL	Third Party Liability.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UPC	Universal product code. Codes contained on the first data bank tape update or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
VFC	Vaccines for Children program.
WAN	Wide area network.

WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women and to infants and children younger than five years old.

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